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11. Differences in older adults' loneliness and depression across Europe

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Abstract. Differences in emotional well-being across several European regions have been observed for both loneliness and depression. These differences can be explained partly by individual characteristics, such as gender, age, marital status and household composition, and the support provided within relationships with kin and other members of the personal network. Previous research into loneliness adopted the view that variegating cultural values also contribute to the understanding of regional differences. In regions characterized by a family orientation, such as southern Europe, living alone is loneliness-provoking since people without a partner are expected to live with their families. In case of an individualistic orientation, such as in Northern regions, older adults without a partner prefer to live alone. With respect to regional differences in depression, no attempt has been made as yet to explain these from cultural values in society. The present paper presents an overview of regional differences in well-being and related characteristics and attempts to link these differences to societal values.

11.1. Introduction

Cross-national comparisons of the circumstances of older adults have largely focused on issues that have immediate policy relevance such as finances, health, and care. Little attention has been paid to more elusive issues such as loneliness or other indicators of subjective well-being. The lack of attention is surprising, given that becoming old is often equated with becoming lonely.

Popular belief holds that the elderly are an overwhelmingly lonely group (Revenson, 1986). In a recent US survey, for example, 38 per cent of those under 65 named loneliness as a very serious problem for older adults (National Council on the Aging, 2000). The notion that people become lonelier as they get older is not supported by empirical research. Results from cross-sectional studies

suggest that loneliness is common only among the very old (see e.g. Perlman and Peplau, 1984 and De Jong Gierveld, 1998 for overviews of studies on age differences in loneliness). Between 20 and 30 per cent (depending on the survey) of middle-aged and young-old respondents report moderate or serious loneliness. However, at advanced ages, the prevalence of loneliness increases. Of those aged 80 and over, 40 to 50 per cent characterize their situation as one of moderate or serious loneliness. The high levels of loneliness at advanced ages are generally linked with widowhood, shrinking social networks and health problems (De Jong Gierveld, 1998; Wenger, Davies, Shahtahmasebi and Scott, 1996).

In this paper we provide an overview of studies on differences across European countries in older adult loneliness. Given the paucity of cross-nationally comparative data on loneliness, we will supplement the findings with data on depression. Loneliness is an unpleasant experience, and it has consistently been linked to depression (Peplau and Perlman, 1982). Despite the frequent co-occurrence of loneliness and depression, the two concepts should be distinguished. Depression is a broader phenomenon than loneliness. Whereas loneliness is primarily linked with deficits in a person's social network, people can be depressed for a variety of reasons. Depressed people are not invariably lonely.

11.2. Cross-national comparisons of loneliness and depression

The 1992 Eurobarometer on elderly Europeans provides data on loneliness among older adults in twelve EU member states. The 1992 Eurobarometer (number 37.2) was a special survey of the population aged 60 and over. As Walker (1993) reports, between five and twenty per cent of older Europeans say they often feel lonely. Wide variations between countries can be observed, however (*table 11.1*, taken from Walker, 1993). The southern European countries show a high prevalence of loneliness, while loneliness among older adults is less common in western and northern Europe.

An earlier study using data from six European regions (urban centers or major cities) participating in the WHO Eleven Country Study on Health Care of the Elderly (Jylhä and Jokela, 1990) reveals roughly the same pattern. Respondents were between the ages of 60 and 90. The results show, for both older adults living alone and those living with one or more others (e.g. a partner, children,

Table 11.1. Older adults who often feel lonely (%)

Greece, Portugal	>19
Italy	15-19
Belgium, France, Ireland, Luxembourg, Spain	10-14
Germany, The Netherlands, UK	5-9
Denmark	<5

Source: Walker (1993); data from Eurobarometer 37.2 (1992); respondents aged 60 and over.

other family members), that the prevalence of loneliness is the lowest in Germany and Finland, higher in Italy and former Yugoslavia, and very high in Greece (table 11.2).

A study by Heikkinen, Berg and Avlund (1995) showed no significant differences in the prevalence of loneliness between three urban locations in Sweden, Finland and Denmark. De Jong Gierveld and Van Tilburg (1999) examined differences in loneliness between older adults in the Netherlands and Tuscany, Italy. At the time of the survey the Dutch respondents were between the ages of 55 and 90, whereas the Tuscan respondents were between the ages of 56 and 91.The authors found no differences in loneliness when the scores on single and direct measures were compared. Examples of such measures are: 'I sometimes feel lonely', and 'If we divide people into: the not lonely, the moderately lonely, the severely lonely, and the extremely lonely, what would you consider yourself to be?' However, examination of loneliness scores based upon an item-scale (De Jong Gierveld and Kamphuis, 1986) indicated higher levels of loneliness in Italy (53 per cent were classified as lonely) than in the Netherlands (32 per cent).

Table 11.2. Older adults who often feel lonely (%)

	Living alone				Living with someone			
	60-74 years		75-89 years		60-74 years		75-89 years	
	Men	Women	Men	Women	Men	Women	Men	Women
Tampere, Finland	28	11	22	20	5	5	3	4
West Berlin, Germany	15	13	21	25	1	2	3	6
Florence, Italy	20	46	42	40	3	15	6	13
Belgrade, f. Yugoslavia	37	44	41	50	5	12	10	21
Amiata, Italy	42	48	39	45	10	15	16	22
Greece	83	85	86	84	25	35	30	37

Source: Jylhä and Jokela (1990); data from the WHO Eleven Country Study, 1979-1980; respondents aged 60-89.

Members of the EURODEP consortium have described the distribution of depressive symptoms and syndromes across Europe. EURODEP is a European collabourative group on depression, involving fourteen research centers from eleven countries. This programme of research was initiated by Copeland of the University of Liverpool (Copeland, 1999), and is supported by the European Commission. The study by Beekman, Copeland and Prince (1999) provides an overview of results from single-country studies reported between 1986 and 1996 (table 11.3). As the authors note, the prevalence of depression varies in those countries for which multiple observations are available. The variation is partly attributable to the use of different measuring instruments. Nevertheless, a clear picture emerges of a high prevalence in Greece and Finland and a much lower prevalence in the other countries. Copeland *et al.* (1999) examined the pre valence and distribution of depressive symptoms among the general population

Table 11.3. Prevalence of depression among older adults

Country	Measure	Prevalence (%)
Greece	CES-D[a]	27.1
Spain	GMS-AGECAT[b]	10.7
France	CES-D	13.6
The Netherlands	CES-D	14.9
The Netherlands	DIS[c]	4.1
The Netherlands	GMS-AGECAT[d]	12.0
UK	GMS-AGECAT	11.2
UK	SAD[e]	9.8
UK	SHORT-CARE[f]	17.8
UK	SHORT-CARE	15.9
UK	SHORT-CARE	10.0
Finland	DSM-III[g]	26.9
Finland	DSM-III	16.5
Denmark	BDI[h]	9.6

[a] Center for Epidemiological Studies Depression Scale (Radloff, 1977);
[b] Geriatric Mental State-Automated Geriatric Examination for Computer Assisted Taxonomy (Copeland *et al.*, 1986);
[c] Diagnostic Interview Schedule (Robins *et al.*, 1985);
[d] Symptoms of Anxiety and Depression Scale (Bedford *et al.*, 1976);
[e] Short version of the Comprehensive Assessment and Referral Evaluation (Gurland *et al.*, 1984);
[f] Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980);
[h] Beck Depression Inventory (Beck *et al.*, 1961).

Source: Beekman, Copeland and Prince (1999); data from the EURODEP Programme; respondents aged 55 and over.

of older adults in nine countries. Older adults with the diagnosis of a depressive illness were excluded from the analysis. The authors observe large differences between the countries, but no striking differences between the north and south of Europe. The latter study included data analyzed by Dewey *et al.* (1993) who reports a prevalence of depression of about fourteen per cent in Liverpool, UK, and of seven per cent in Zaragoza, Spain. The study by Heikkinen, Berg and Avlund (1995) reveals a somewhat higher prevalence in Finland than in Sweden and Denmark.

A general finding is that loneliness and depression are distinct but related phenomena. In the Longitudinal Aging Study Amsterdam (LASA), for example, a firm but not perfect correlation is observed between loneliness (as measured by the De Jong Gierveld scale and De Jong Gierveld and Kamphuis, 1986) and depression scores (as measured by the CES-D; Beekman *et al.*, 1995 and Radloff, 1977). Among 3015 older adults aged 54-85 years (observations in 1992-1993) the Pearson correlation between the two measures is 0.48 (own analyses). Cross tabulation of dichotomized scale scores reveals that 64 per cent of the sample are not lonely and have no depressive symptoms, 4 per cent are not lonely and have depressive symptoms, 21 per cent are lonely and have no depressive symptoms, and 10 per cent are lonely and depressed.

Given this association, one would expect corresponding country rankings with respect to loneliness and depression. The findings presented above show that this is indeed the case: loneliness and depression are very common in Greece, less common in France, followed by the UK, the Netherlands and Denmark. However, the results for Finland, with a low prevalence of loneliness and a high prevalence of depression, do not follow this pattern. The high rates of depression in Finland might be a methodological artifact. Finland is the only country in which depression was measured by means of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The World Values Study Group (1994) has data on feelings of loneliness and depression for a wide range of European countries. These data were collected in the beginning of the1980s. The following question was put to the respondents: "We are interested in the way people are feeling these days. During the past few weeks, did you ever feel very lonely or remote from other people? (no/yes)". Cross tabulation of individual scores of older people (N=4843) revealed that 64 per cent were not lonely and had no depressive symptoms, 12 per cent were not lonely and had depressive symptoms, 11 per cent were lonely and had no depressive symptoms, and 14 per cent were lonely and depressed. At the country

level, the correlation between loneliness and depression was 0.84 (N=31). Differences in loneliness and depression were observed between northern, western, southern and eastern Europe for both loneliness ($F(4856,3)=11.2$, $p < 0.001$) and depression ($F(4856,3)=24.2$, $p < 0.001$). However, the ranking was different than as described above. Equal proportions of older adults in western and southern Europe were lonely and depressed (about 24 per cent; there were fewer lonely and depressed older adults in northern Europe (16 and 12 per cent, respectively) and more in eastern Europe (29 and 32 per cent, respectively). Moreover, there was a large variation across countries within specific regions (see table 11.4).

11.3. Explanations of cross-national differences

If cross-national differences are observed, the question arises as to how to explain them. What factors account for differences across countries? Three types of explanations can be put forward. The first is that the inhabitants of the

Table 11.4. Feeling lonely and feeling depressed, 1981-1984 (%)

	Lonely	Depressed		Lonely	Depressed
North			*South*		
Denmark	13	16	Spain	25	23
Norway	20	16	Portugal	16	23
Sweden	7	9	Italy	21	23
Iceland	15	7	Turkey	36	59
Finland	20	11			
			East		
West			East Germany	45	51
Ireland	26	26	Poland	23	30
Northern Ireland	12	22	Czech	19	21
Britain	18	23	Slovenia	23	25
The Netherlands	23	19	Hungary	28	35
Belgium	25	18	Bulgaria	28	27
France	12	8	Romania	28	35
West Germany	45	49	Byelorussia	27	19
Austria	30	37	Lithuania	23	37
Switzerland	9	8	Latvia	14	9
			Estonia	24	19
			Moscow	31	21
			Russia	33	31

Source: World Values Study Group (1994); respondents aged 65 years or older.

different countries have different individual characteristics. Here the differences are attributable to differences in population composition. The second explanation is that the countries as a whole are different. In this kind of an explanation references might be made to differences in cultural systems, in economic organization, and so forth. The third explanation is that there is an interaction between individual and country characteristics. The three types of explanations are depicted in figure 11.1. One should note that these explanations are not mutually exclusive. In what follows, we describe, for purposes of illustration, examples of empirical studies in which attempts have been made to unravel the different kinds of explanations of cross-national differences in loneliness or depression among older adults.

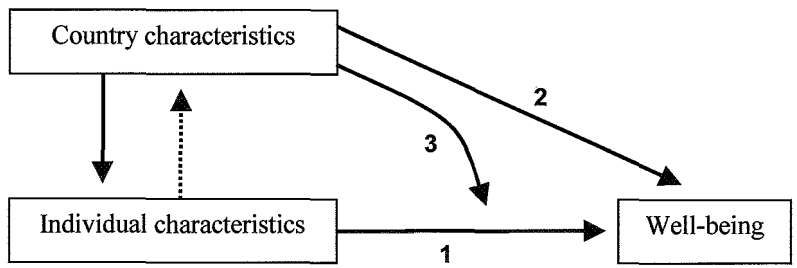
Study 1

A common procedure is to examine whether the distribution of determinants differs across countries, and subsequently whether this distribution accounts for cross-national differences. This procedure typically involves a two-step analysis.

First, a multivariate analysis is conducted in which cross-national differences are estimated after controlling for individual characteristics. Next, interaction effects of individual determinants and the country are examined to assess whether the associations vary across countries.

An example of such a two-step analysis is the study by Stack (1998) on cross-national differences in loneliness among older adults. Results from the first step show that individual differences in marital and parental status, self-reported health, socio-economic status, education, church attendance and gender

Figure 11.1. Explanations of cross-national differences



contribute to the explanation of loneliness. After controlling for these factors, loneliness still varies among nations (table 11.5). The Italians report the highest loneliness, and the Danish the lowest. The second step consists of separate regressions, one for each country. The coefficient for marriage for each nation is compared to that of the US (B=-0.228). The results indicate that there are two 'deviant' countries, Belgium and Northern Ireland, in which there is no significant association between being married and loneliness. Furthermore, the *z*-statistics in the last column indicate that only one nation's marriage coefficient is significantly different from that of the US, i.e. Denmark where being married provides better protection from loneliness than in other countries. Stack concludes that the strength of the association between marriage and loneliness is nearly invariant across the nations in the study. However, he does not provide a rationale for the differences in the level of loneliness across the countries.

Study 2

Braam *et al.* (2001), using data from the EURODEP programme, studied religiosity as a determinant of depression, both at the individual and country

Table 11.5. Step 1: Regression of loneliness on country, controlled for marital and parental status, self-reported health, socio-economic status, education, gender and church attendance (standardized coefficients); Step 2: The effect of being married on loneliness (unstandardized coefficients); Difference in slopes test (DZ-score)

	Step 1	Step 2	
	Beta	B	DZ-score
Italy	0.07	-0.312*	-0.59
Spain	-0.01	-0.324*	-0.93
Northern Ireland	-0.02	-0.326	-0.43
France	-0.04	-0.444*	-1.78
Ireland	-0.04	-0.312*	-0.67
Belgium	-0.05	-0.110	1.03
Britain	-0.05	-0.288*	-0.53
Iceland	-0.05	-0.351*	-0.93
Norway	-0.05	-0.309*	-0.75
Sweden	-0.05	-0.392*	-1.24
Germany	-0.07	-0.200*	0.25
The Netherlands	-0.07	-0.333*	-0.91
Denmark	-0.12	-0.470*	-2.18*

* $p < 0.05$.

Note: The USA is category of reference; Non-European countries are omitted from the table.

Source: Stack (1998); data from the World Values Surveys, 1981-1983.

level. Results of a first analysis showed that regular church-attendance was associated with a lower prevalence of depression. In a second analysis, five different religious climate estimate were derived from the European Values Study using the national percentage of (a) Roman Catholics, (b) Protestants and (c) weekly church-attenders, and the mean national scores on (d) an orthodoxy scale and (e) a religious devotion index. Applying multilevel analysis, respondents were nested within countries. Controlling for gender and age, only one significant association at the country level was observed: Depression was low if the national rate of weekly church-attendance was high (Beta=-0.27; $p < 0.05$). The rate of weekly church-attendance was low in Iceland, Sweden and Finland (<5 per cent), higher in western Europe (Germany, The Netherlands, Belgium, France and England; between 10 and 27 per cent), followed by Spain (30 per cent) and Italy (38 per cent), and highest in Ireland (81 per cent).

Study 3

Jylhä and Jokela (1990) formulated the hypothesis that older adults who live alone are more likely to feel lonely in countries where living alone is uncommon. In other words, loneliness should be more prevalent in societies where living alone is more of an exception than a rule. The authors based this hypothesis on Johnson and Mullins' (1987) concept of the 'loneliness threshold'. This concept holds that people have their own minimal standards for social contacts, determined by two closely related factors: The cultural value system in a society and the amount of social contacts to which people are normally accustomed. In more collectivist cultures, pressures and expectations of communality are likely to be higher than in a more individualist type of culture. Living alone is more typical of individualistic than of collectivist societies.

As reported in table 11.2, Jylhä and Jokela observed that older adults living alone were generally more likely to report loneliness than those who were living with one or more others at the time of the interview. Their data also showed that living alone became progressively less common from northern Europe to southern Europe, whereas experiences of loneliness progressively increased. In line with their hypothesis, Jylhä and Jokela found that levels of loneliness were higher in places where living alone was rarest. In Finland and Germany about 20 per cent of the people living alone were lonely, in Italy the proportion was about 40 per cent, and in Greece the proportion was higher than 80 per cent. Experiences of loneliness also increased progressively from north to south for the married. Among married women, for example, the figures were 4 per cent

for Tampere, 11 per cent for Florence and 44 per cent for Greece. A multivariate analysis of the data of older adults in Finland and Greece, the two most distant areas (not only geographically but also in cultural terms), revealed that the cross-national differences continued to exist when differences in health and the proportion living alone were taken into account. According to Jylhä and Jokela, the explanation should be sought in cultural factors. Presumably, Finnish older adults have fewer expectations about community and frequent and close interaction with friends and family than do Greek older adults. The reason Finnish older adults are less prone to loneliness than are the Greek is that they are less likely to meet disappointments in their relationships.

11.4. Conclusion

The pattern of findings emerging from the overview of studies on cross-national differences within Europe in older adult loneliness and depression, is one of progressively increasing levels from north to south. One should note, however, that the differences in loneliness are more consistent than are the differences in depression. Interestingly, this pattern is contrary to stereotypes which tend to equate the individualism and de-familialism (Esping-Andersen, 1999) of the Scandinavian and the Continental European countries with high levels of social isolation. As the findings reported in this paper show, the lowest levels of loneliness and depression are found in countries purported to have relatively 'weak family links' (Reher, 1998) and the highest levels are found in countries with relatively 'strong family ties'.

Insofar cross-national comparative analyses of determinants of older adult loneliness and depression have been carried out (e.g. analyses of differences in marital status, living arrangement, health, and religiosity), the findings are parallel to those for loneliness and depression. In other words, between-country differences in loneliness and depression are —partially at least— attributable to between-country differences in population composition. For example: countries with a relatively high proportion of older adults living alone tend to have a relatively high proportion of lonely older adults.

The findings are mixed regarding the question of whether differences in population composition provide satisfactory explanations of cross-national differences in loneliness and depression. Cultural factors might account for differences in loneliness and depression over and above differences in the distribution of individual determinants. In the first study, for example, cross-

national differences in loneliness remained after controlling for individual determinants. We would like to note, however, that only a limited number of determinants were considered in the analyses. Indicators of social integration, such as the participation in personal networks and in a wide variety of organizations, which are known to protect against loneliness (De Jong Gierveld, 1998) were not incorporated in the analyses. It is not inconceivable that the inclusion of these and other variables would reduce or fully account for cross-national differences. The first study also showed that country-specific effects of marriage were rare. A drawback of study 2 is the absence of individual variables on religiosity. Inclusion of these variables might better predict older adults' depression, resulting in fewer unexplained cross-national differences. The central hypothesis within study 3 involved an interplay between personal experiences and cultural characteristics, namely that loneliness would be more prevalent in societies where living alone is less common. The results corroborated the hypothesis. Cautionary remarks are in order. Firstly, as in most studies, societal characteristics were not included in the analysis. Of course the small number of cases on the country level does not make it easy to include several, more refined characteristics. Secondly, only a small number of explanatory individual variables were considered.

Van Tilburg *et al.* (1998) studied differences in loneliness among older adults in Tuscany, Italy, and the Netherlands in greater detail. Fourteen indicators of social integration were included in the analyses. Results showed a number of interaction effects of country and individual characteristics, while a small, but significant, main effect of differences in loneliness between the Tuscans and the Dutch remained after controlling for differences in the distribution of individual characteristics. This particular study suggests that societal culture affects older adults' well-being over and above their individual circumstances. Nevertheless, the main finding was that the higher level of loneliness among the Tuscans was attributable to being less socially integrated than the Dutch. On the average, Tuscan older adults had fewer friends, less intensive contacts with their neighbors, and fewer exchanges with family members, and that was why they were more vulnerable to loneliness than their Dutch counterparts.

In our view, cross-national comparative research on older adult subjective well-being stands to gain from (a) a focus on a wide range of countries representing different European regions, and (b) the incorporation of relevant variables at both the level of the society and at the individual level. 'Relevant' variables are

those that capture the ways in which societies promote or hinder older adults' social integration.

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